

How a Rabbi's Sermon Resolved My *Tarasoff* Conflict

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Houses of worship are not places where psychiatrists typically expect to gain insight into forensic issues. But a few years ago, a rabbi's comments on a familiar passage from Leviticus helped me resolve an intrapsychic conflict that had troubled me for years, ever since I learned about the *Tarasoff* decisions.^{1,2}

When I give first-year residents their introductory lessons on legal issues and psychiatry, "Tarasoff" is a name that, invariably, they have already heard. Most of the residents mistakenly think (along with many of their more senior colleagues in the mental health professions) that *Tarasoff* stands for a "duty to warn" someone when a patient appears dangerous.

As every regular reader of the Journal knows, the *Tarasoff* decisions arose when the parents of Tatiana Tarasoff, who had been killed in 1968 by fellow student Prosenjit Poddar, sought to sue Poddar's treating mental health professionals and their employer, the University of California. Before the killing, while Tatiana was visiting Brazil, Poddar had told his psychologist that he was thinking about killing a young woman. The psychologist guessed who the woman was and informed the campus police, who checked on Poddar but did not detain him. Poddar stopped seeing the psychologist, and after Tatiana returned to California, Poddar fatally stabbed her.³

In its first (1974) decision on this matter,¹ the California Supreme Court ruled that the parents' cause of action was valid, because the psychologist's response had been insufficient. The psychologist also should have warned Tatiana about the danger Pod-

dar posed. After the defendants, the American Psychiatric Association, and other professional societies asked for and received a rehearing, the California Supreme Court issued a second ruling that formulated the clinician's duties even more broadly: "once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger" (Ref. 2, p 439).

The volume of commentary on *Tarasoff*, in both legal publications and those of mental health professionals, has been enormous, and rightly so. California's *Tarasoff* case and (as Alan Stone⁴ cleverly puts it) its "progeny" in other jurisdictions have profoundly altered the way we mental health professionals think about our responsibilities to our patients and society. The residents I teach readily accept the idea that if a patient poses enough of a danger, the psychiatrist is duty bound to intervene, even if intervening means doing something beyond what is needed to treat the psychiatric problems the patient is experiencing.

Immediately after the *Tarasoff* decisions, what bothered mental health professionals most was the expectation that we should violate therapeutic confidentiality. Commentators, including Alan Stone,⁵ objected on practical grounds: Poddar had left treatment after his therapist had called the police, and many other persons might not seek treatment at all without assurance that their most personal thoughts (including some violent thoughts that are merely fantasies) would be kept private. The second *Tarasoff* decision explicitly acknowledged this problem, recognizing "that the open and confidential character of psychotherapeutic dialogue encourages patients to

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express threats of violence, few of which are ever executed” (Ref. 2, p 441) and that disclosing such threats could disrupt treatment. But medical case law offered plenty of precedent for breaching confidentiality when, for example, a communicable disease threatens family members. By a utilitarian calculus more insisted on than explained, the *Tarasoff* majority decided that the value of confidential therapy had limits, and “must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins” (Ref. 2, p 442).

Subsequent research suggested that therapists’ fears were unfounded. *Tarasoff* did not discourage people from seeking psychotherapy,⁴ and fulfilling *Tarasoff* duties could even enhance treatment.⁶ But my disquietude was not addressed by such findings. One reason was that the idea of violating confidentiality when a life was in danger just did not bother me much, nor (according to surveys) did it bother most psychotherapists.^{7,8} As one of my residency supervisors adroitly put it, any psychiatrist would be crazy not to issue a warning if doing so would prevent a patient from killing someone. So for several years, I remained perplexed about what it was in *Tarasoff*, if not the required breach of confidentiality, that irked me so much.

I had learned about *Tarasoff* obligations in the early 1980s. At the time, available research suggested that (1) persons with mental disorders did not act violently at rates above those of the general population, if one controlled for sociodemographic factors (such as youthfulness and poverty), and (2) mental health professionals could not predict violence.^{9–11} If these things were true, I thought, then the *Tarasoff* duty represented a dual form of unfairness. For no valid reason, *Tarasoff* stigmatized psychiatric patients as uniquely dangerous and singled them out for embarrassing, discriminatory treatment. To add insult to injury, *Tarasoff* implied that there were professional “standards” for detecting “serious danger” to others, when in fact, predicting violence was something we mental health professionals could not really do.

By the mid-1990s, scientific knowledge about mental disorders and violence prediction had advanced enough to address both of these objections. It turned out, first, that mental illness was a legitimate risk factor for violence. In 1990, Swanson and colleagues¹² published a study (based on data originally

gathered in the 1980s for the Epidemiologic Catchment Area study) showing that the presence of substance use problems or serious mental illness increased violence rates in adults, even after factoring in sex, age, and income. Two years later, Link and colleagues¹³ published a study in which they controlled for additional variables (e.g., an individual’s neighborhood) and found again that having been a “mental patient” increased one’s risk of violence.¹³

Second, researchers also found that mental health professionals actually had some ability to predict violence. Beginning in the mid-1980s, what John Monahan¹⁴ termed a “second generation” of research on violence prediction suggested that the clinician’s assessments of risk for short-term violence might be valid.^{15,16} Re-evaluation of first- and second-generation studies showed that both short- and long-term predictions had similar, clearly-above-chance levels of accuracy.¹⁷

But once these objections to *Tarasoff*’s requirements were addressed, other problems arose. Granted that psychiatric patients are more likely to do violent things and that mental health professionals have some ability to distinguish those persons who will be violent from those who will not, even recently developed actuarial methods of prediction—which some argue should supplant clinical predictions¹⁸ and which have accuracy ratings well above chance—are far from perfect. Now, the *Tarasoff* decision acknowledges that psychiatric predictions cannot be perfect. But as Paul Appelbaum points out, *Tarasoff* also implies that a mental health professional is obligated to act “only when a threshold of probability is crossed,”¹⁹ or when a certain level of risk is reached. The question is, what is that level? If, as *Tarasoff* says, a therapist is duty-bound to protect the public when a “patient poses a serious danger of violence,” what probability of risk is “serious”?

I suspected that there was no agreement about this probability, and Kathleen Hart and I²⁰ found a way to demonstrate this empirically. We reasoned as follows. Often, potentially violent persons are brought to psychiatric emergency rooms, where an option for fulfilling the duty to protect is to arrange for involuntary hospitalization. However beneficial this practice is to the public, it deprives those persons who are hospitalized of their liberty, and, given that psychiatric predictions are not perfect, many of the persons deprived of liberty would not have been violent had

they been released. We felt that any prediction instrument should be used in such a way as to take into account the harm to patients caused by loss of liberty along with benefits to the public from hospitalizing truly dangerous persons.

Our study asked young adults to imagine they were helping clinicians calibrate a “Future Violence Test” which, although fairly accurate, sometimes made mistaken predictions. The subjects’ responses would help clinicians balance wrongful predictions of violence (leading to unnecessary hospitalization) with wrongful predictions of nonviolence (leading to injury to a third party). We then asked subjects to tell us how many days they would be willing to spend in a hospital to avoid being attacked by a man wielding a knife. Answers to this and other questions would allow us to calculate how an accurate but imperfect prediction measure could be used to decide who should be released from a psychiatric emergency room and who should be hospitalized.

It turned out, however, that our subjects varied enormously on the amount of hospitalization they would accept to avoid being attacked. On one end of the spectrum were many subjects who were willing to undergo several years of confinement; on the other end were many subjects who would not spend even one day in a psychiatric ward to avoid an armed physical attack. I repeated the study years later, asking a group of mental health professionals similar questions, and got the same wide range of responses. When, as fairness requires, people consider the effects of involuntary hospitalization on patients as well as its benefits to public safety, there is no agreement on how much liberty should be sacrificed to prevent violence. Even if violence prediction tools were very accurate, there could be no social agreement about how to use those tools or about what probability of risk necessitates taking steps to protect third parties.²¹ In other words, even if mental health professionals could accurately gauge levels of risk, there could be no societal agreement about what level of risk is serious enough to trigger a *Tarasoff* duty.

Nonetheless, the *Tarasoff* duty remained and came to my state in 1997, despite a statute²² that many Ohio mental health professionals thought had immunized us from liability for harm to third parties. In *Morgan v. Fairfield Family Counseling Center*,²³ the Ohio Supreme Court decided that the statute only conferred immunity related to testimony at civil commitment hearings. The *Morgan* suit was brought

against a mental health center and its professionals following a July 1991 episode in which Matt Morgan was playing cards at home with his parents and sister. He excused himself to go upstairs, returned with a gun, and shot his parents to death, wounding his sister in the process. He was charged with murder, but a jury found him not guilty by reason of insanity.

At the time of the shootings, Mr. Morgan was a young man who had experienced mental problems for a few years and who had gotten treatment and antipsychotic drugs in Philadelphia before being sent back to Ohio with instructions to continue care. But a psychiatrist at the Fairfield Center discontinued his medication, and when his condition deteriorated months later, other clinicians at the Center decided they could not force medication or hospitalization on him.

The plaintiffs believed that the Fairfield Center’s actions and decisions were negligent, and the Ohio Supreme Court stated that the plaintiffs had valid grounds to sue. Though ordinarily there is no duty to stop one person from doing harm to another, a “special relationship” exists between a psychotherapist and a patient, said the *Morgan* majority, and this gives the therapist “a duty to exercise his or her best professional judgment to prevent such harm from occurring” (Ref. 23, pp 1328–9).

As troublesome as this requirement was—how can any judgment look, in retrospect, to have been one’s “best” if it later turns out to have been wrong?—what was even more irritating was the *Morgan* majority’s characterization of the purpose of mental health treatment: to control violence.

The Court reasoned that “neuroleptic medication controls symptoms of schizophrenia in approximately seventy percent of schizophrenics,” that while taking drugs Mr. Morgan had been “a medication-controlled. . . patient,” and that if he had “remained on medication, he would not have had the overt psychotic symptoms that led him to kill his parents and injure his sister” (Ref. 23, pp 1323–4). Fairfield clinicians also had the power to initiate civil commitment procedures. “Thus,” said the *Morgan* majority, “we conclude that the psychotherapist-outpatient relationship embodies sufficient elements of control to warrant a corresponding duty to control” (Ref. 23, p 1324).

An underlying fear of mental patients had clearly been a driving force in several of the *Tarasoff* progeny and in the *Tarasoff* decision itself, which states:

In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal. If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment. The containment of such risks lies in the public interest [Ref. 2, p 442].

But *Morgan* does not place the risks of patients in a context of competing therapeutic duties. Citing Ohio's civil commitment statutes as evidence of danger, the *Morgan* court simply declared:

Society has a strong interest in protecting itself from those mentally ill patients who pose a substantial risk of harm. . . . To this end, society looks to the mental health profession to play a significant role in identifying and containing such risks. . . . The mental health community, therefore, has a broadly based responsibility to protect the community against danger associated with mental illness. . . . This responsibility is analogous to the obligation a physician has to warn others of his patient's infectious or contagious disease [Ref. 23, p 1324 (citations omitted)].

I had entered psychiatry to help patients become more autonomous and to fulfill their human potential. In *Morgan*, however, Ohio's Supreme Court said my job was to contain risks posed by dangerous people whose willful acts would otherwise spread like deadly germs.

After *Morgan* was issued, Ohio mental health professionals asked the state legislature to craft a more reasonable rule about when liability could be imposed. In a 1999 statute²⁴ passed explicitly to override *Morgan*, Ohio legislators enacted a standard very similar to one proposed in the late 1980s by the American Psychiatric Association.²⁵ As is the case in several other states with similar statutes, an Ohio mental health clinician now can be liable for harm to third parties only when a patient makes a specific threat toward an identifiable person or structure and has the intent and ability to carry out the threat. When such a threat is made, taking one of several actions—arranging for hospitalization, changing treatment, or warning the police and the potential victim—immunizes the clinician from liability.

Ohio's statute was a big improvement over *Morgan*'s "best professional judgment" standard. Yet the statute's passage still left me feeling that psychiatric patients were being singled out unfairly as especially violent and that mental health clinicians were assigned the stigmatizing duty of controlling them. I was wrong about this, however, and realized why I was wrong several months later in, of all places, a synagogue.

I had traveled to my home town, where the son of a childhood friend was to have his Bar Mitzvah. Each week at synagogues around the world, Sabbath morning services include a public reading from the Torah scroll (the Five Books of Moses), and my friend had honored me by asking me to chant part of the week's scriptural selection. The part my friend assigned to me included famous verses from Leviticus 19, which the King James translation renders as follows:

[16] Thou shalt not go up and down as a talebearer among thy people: neither shalt thou stand against the blood of thy neighbor: I am the LORD.

[17] Thou shalt not hate thy brother in thine heart: thou shalt in any wise rebuke thy neighbor, and not suffer sin upon him.

[18] Thou shalt not avenge, nor bear any grudge against the children of thy people, but thou shalt love thy neighbor as thyself: I am the LORD.

The commandment to love one's neighbor as oneself will be familiar to almost every Journal reader. It also appears six times in the Christian Testament,²⁶ and is a central tenet of shared Judeo-Christian ethics. Perhaps less familiar is the commandment that appears two verses earlier, forbidding one from standing "against the blood" of one's neighbor.

In his comments on the week's portion, Rabbi David Krishef focused on the commandment in verse 16, which in Hebrew reads, "*lo ta' amod al-dam rei'echa*." Literally, these words say, "Do not stand on the blood of your neighbor," but the meaning of the phrase is better captured in the Jewish Publication Society's 1917 translation, "neither shalt thou stand idly by the blood of thy neighbor." Rabbi Krishef pointed out that according to long-standing Jewish tradition, this verse instructs us to do what we can to save our fellow human beings from danger. If one sees another person drowning or sees robbers attacking him and can save him, one is obligated to do so; if one knows that evildoers are conspiring against another person, one should warn the potential victim; if one can persuade one's fellow not to harm another, one should try to do so.

The crucial points for me were twofold. First, this is a commandment that applies not just to psychiatric patients or mental health professionals, but to everyone. Anglo-American common law does not recognize a legal obligation to aid other persons who are in peril unless there is a "special relation" between the parties. With all the flagrantly evil deeds that people commit, courts have been less concerned

about sanctioning someone who merely “did nothing.” Moreover, it is difficult to set clear, general standards of unselfish service to our fellow creatures.²⁷ But the absence of a legal obligation does not negate the existence of a moral obligation to save others, and the absence of clear standards to define the obligation does not mean that there are never clear cases where we know another person is in danger and should do something reasonably simple to avert the danger.

This leads to the second point. Even though Ohio’s duty-to-protect statute applies only to mental health professionals, its requirements could be fairly applied to anyone. The statutory circumstances in which professionals must act do not imply or require any ability to predict violence or to calculate a level of risk. Instead, the professionals only need take patients at their word when they make explicit, specific threats and size up—just as would other intelligent citizens exercising their common sense—whether the patients really mean what they say and really could carry out the threats. If a threat represents both an intention and the ability to so act, the professional is then required to respond as any reasonable person should respond: do what he can to intervene. Of course, the power to arrange involuntary hospitalization is a legally bestowed capacity unique to mental health professionals, but it has parallels in other distinctive capacities that other citizens—for example, lifeguards, crossing guards, firefighters, and police—exercise.

Moreover, the availability of unique capacities is why people seek help from mental health professionals in the first place. Who among us would want to be treated by a mental health professional who could easily stop us from harming someone else, but declined to do so? If we have patients who make explicit threats that they can and will carry out and we do nothing to stop them, we do a disservice to our patients themselves, even if we think we should have no obligation for the harm our patients do to third parties.

Following the Rabbi’s sermon, I am much less troubled by my *Tarasoff* duties. If those duties are defined, as they are in Ohio, in such a way that any citizen could be similarly obligated and if those duties require me to do only what I am morally obligated to do, I no longer have any conflict about being legally obligated by them.

References

1. *Tarasoff v. Regents of Univ. of Cal.*, 529 P.2d 553 (Cal. 1974)
2. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334 (Cal. 1976)
3. Buckner F, Firestone M: “Where the public peril begins”: 25 years after *Tarasoff*. *J Legal Med* 21:187–222, 2000
4. Stone AA: The *Tarasoff* case and some of its progeny: suing psychotherapists to safeguard society, in *Law, Psychiatry and Morality: Essays and Analysis*. Washington, DC: American Psychiatric Association, 1984, pp 161–90
5. Stone AA: The *Tarasoff* decisions: suing psychotherapists to safeguard society. *Harv L Rev* 90:358–78, 1976
6. Wulsin LR, Bursztajn H, Gutheil TG: Unexpected clinical features of the *Tarasoff* decision: the therapeutic alliance and the “duty to warn.” *Am J Psychiatry* 140:601–3, 1983
7. Givelber DJ, Bowers WJ, Blich CL: *Tarasoff*, myth and reality: an empirical study of private law in action. *Wis L Rev* 1984:443–97, 1984
8. Rosenhan DL, Teitelbaum TW, Teitelbaum KW, et al: Warning third parties: the ripple effects of *Tarasoff*. *Pac Law J* 24:1165–232, 1993
9. Monahan J: Mental disorder and violent behavior: perceptions and evidence. *Am Psychol* 47:511–21, 1992
10. Monahan J: The clinical prediction of violent behavior. DHHS Publication ADM 81-92. Rockville, MD: National Institute of Mental Health, 1981
11. Walsh E, Fahy T: Violence in society. *BMJ* 325:507–8, 2002
12. Swanson JW, Holzer CE, Ganju VK, et al: Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys. *Hosp Community Psychiatry* 41:761–70, 1990
13. Link BG, Andrews H, Cullen FT: The violent and illegal behavior of mental patients reconsidered. *Am Sociol Rev* 57:275–92, 1992
14. Monahan J: The prediction of violent behavior: toward a second generation of theory and policy. *Am J Psychiatry* 141:10–5, 1984
15. McNeil DE, Binder RL: Predictive validity of judgments of dangerousness in emergency civil commitment. *Am J Psychiatry* 144:197–200, 1987
16. Binder RL: Are the mentally ill dangerous? *J Am Acad Psychiatry Law* 27:189–201, 1999
17. Mossman D: Assessing predictions of violence: being accurate about accuracy. *J Consult Clin Psychol* 62:783–92, 1994
18. Quinsey VL, Harris GT, Rice ME, et al: *Violent Offenders: Appraising and Managing Risk*. Washington, DC: American Psychological Association, 1998
19. Appelbaum PS: Ask the experts. *Am Acad Psychiatry Law Newsletter* 17:19, 1992
20. Mossman D, Hart KJ: How bad is civil commitment?—a study of attitudes toward violence and involuntary hospitalization. *Bull Am Acad Psychiatry Law* 21:181–94, 1993
21. Mossman D: Dangerousness decisions: an essay on the mathematics of clinical violence predictions and involuntary hospitalization. *Univ Chicago Law School Roundtable* 2:95–138, 1995
22. Ohio Revised Code Ann. § 5122.34 (West 2004)
23. *Estates of Morgan v. Fairfield Family Counseling Center*, 673 N.E.2d 1311 (Ohio 1997)
24. Ohio Revised Code Ann. § 2305.11 (West 2004)
25. Appelbaum PS, Zonana H, Bonnie R, et al: Statutory approaches to limiting psychiatrists’ liability for their patients’ violent acts. *Am J Psychiatry* 146:821–8, 1989
26. Matthew 19:19, 22:39; Galatians 5:14; James 2:8; Mark 12:31; Romans 13:9
27. Keeton WP, Dobbs DB, Keeton RE, et al: *Prosser and Keeton on the Law of Torts* (ed 5) § 56. St. Paul, MN: West Group, 1984